2. Physical Therapy Visit - These services shall be given in accordance with the responsible physician's written order by a physical therapist or physical therapy assistant currently licensed in the State of Mississippi to practice as a physical therapist or physical therapist assistant. The physician's order shall be specific as to modalities to be utilized and frequency of therapy. Each visit should be for a period of not less than thirty (30) minutes.

   These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

3. Speech Therapy Visit - The speech pathologist shall be currently licensed by the Mississippi State Department of Health at the time the services are provided. The audiologist shall be currently licensed by the Mississippi State Department of Health. Speech pathology and audiology services shall be given in accordance with the responsible physician's written order by a licensed speech pathologist or a licensed audiologist. The frequency of service shall be specified in the physician's order. Each visit should be for a period of not less than thirty (30) minutes.

   These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

4. Home Health Aide Visit - These services shall be given under a physician's order and shall be supervised by a Registered Nurse. When appropriate, supervision may be given by a physical therapist, a speech therapist, or an occupational therapist. These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

C. Trend Factor

A trend factor will be computed in order to adjust costs for anticipated increases or decreases due to changes in the economy. This will be done by using the DRI/McGraw-Hill Health Care Costs - National Forecasts HCFA Home Health Agency Market Basket. The moving averages from the fourth quarter of the previous calendar year, prior to the start of the rate period, used are Wages and Salaries, Employee Benefits, Fixed Capital, Medical Equipment, Utilities, Telephone, Paper Products, Postage, Administrative Costs, Transportation, Insurance, and Miscellaneous. Relative weights are obtained from the same period National Market Basket Price Proxies - Home Health Agency Operating Costs.

An example of the computation of the trend factor is described below.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
EXPENSE CATEGORY	RELATIVE WEIGHT	ADJUSTED RELATIVE WEIGHT COL 2/COL 1 TOTAL LINE	PERCENT GROWTH QUARTER 96:4	TREND FACTOR COL 3 * COL 4
Wages & Salaries	64.23%	0.6480	0.029	0.0188
Employee Benefits	13.44%	0.1356	0.018	0.0024
Fixed Capital	1.76%	0.0178	0.032	0.0006
Transportation	3.41%	0.0344	0.027	0.0009
Utilities	0.83%	0.0084	0.031	0.0003
Telephone	0.73%	0.0074	0.014	0.0001
Paper Products	0.53%	0.0053	0.053	0.0003
Postage	0.72%	0.0073	0.000	0.0000
\dministrative Costs	7.59%	0.0766	0.033	0.0025
Medical Equipment	0.88%	0.0000	0.000	0.0000
Insurance	0.56%	0.0056	0.022	0.0001
Miscellaneous	5.32%	0.0537	0.028	0.0015
Total	100.00%			
Less: Medical Supplies & Equipment	-0.88			
Adjusted Total	99.12%	1		0.0275

The trend factor of 2.75%, as determined above for a one year period, will be adjusted based on the cost report period in order to trend costs from the mid-point of the cost report period to the mid-point of the rate period.

D. Setting of Type of Visit Ceilings and Rates

1. Skilled Nursing Visit rates are determined in accordance with the following rate methodology. Home Health Agencies are reimbursed for skilled nursing visits at the lower of the following:

(a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

(1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or

(b) the sum of the following:

(1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and

(2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.

2. Physical Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of ~~$48.60~~. $65.00

3. Speech Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of ~~$60.46~~. $65.00

4. Home Health Agencies are reimbursed for home health aide visits based on the following methodology:

(a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

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(1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above.

V. New Providers

1. Changes of Ownership

For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. the change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Prior to the DOM's concurrence of a change of ownership transaction, the following information is required in order for the DOM to determine the appropriate allowance for depreciation and interest on capital indebtedness:

a. the prior owner's basis in the assets sold;

b. the purchase amount of these assets by the new owner;

c. the amount of annual depreciation and interest expense for the buyer; and

d. a description of the assets being purchased.

A home health agency which undergoes a change of ownership must notify the DOM in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under DOM policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

The new owner will be reimbursed at the previous owner's rate until the rate is adjusted based on the new owner's initial cost report. This adjusted rate will be effective retroactive to the date of the change of ownership. A prospective rate will also be determined based on this initial cost report.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

VI. Grounds for Imposition of Sanctions

A. Sanctions may be imposed by the DOM against a provider for any one or more of the following reasons:

1. Failure to disclose or make available to the DOM, or its authorized agent, records of services provided to Medicaid recipients and records of payment made therefor.
2. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the DOM or the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification.
3. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

4. Documented practice of charging recipients for services over and above that paid by the Commission.
5. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Director of the Health Care Commission or Medicaid Commission.
6. Failure to meet standards required by State or Federal law for participation.
7. Submission of a false or fraudulent application for provider status.
8. Failure to keep and maintain auditable records as prescribed by the Commission.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.
10. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid Program.
11. Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.
12. Presenting, or causing to be presented, for payment any false or fraudulent claims for services or merchandise.
13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the Commission or usual and customary charges as allowed under Commission regulations).
14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

15. Exclusion from Medicare participation because of fraudulent or abusive practices.

16. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

B. Sanctions

The following sanctions may be invoked against providers based on the grounds specified hereinabove:

1. Suspension, reduction, or withholding of payments to a provider;

2. Suspension of participation in the Medicaid Program; and/or

3. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients, their families or any other third party.

C. Right to a Hearing

Within thirty (30) calendar days after notice from the Director of the Commission of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forthwith particularly the facts which the provider contends places him in compliance with the Commission's regulations or his defenses thereto.

Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the claims or amounts in question.

Unless a timely and proper request for a hearing is received by the Commission from the provider, the findings of the Commission shall be considered a final and binding administrative determination.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Mississippi Medicaid Commission.

VII. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public.

VIII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

IX. Durable Medical Equipment

A. The payment for purchase of Durable Medical Equipment (DME) is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.

B. The payment for rental of DME is made from a statewide uniform fee schedule based on 10 percent of the above purchase allowance not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid recipient. The exception is Oxygen Equipment which will be reimbursed a monthly rental as approved.

C. The payment for purchase of used DME is made from a statewide uniform fee schedule based not to exceed 50 percent of the above purchase allowance.

D. The payment for repair of DME is the cost, not to exceed 50 percent of the above purchase allowance.

E. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Durable Medical Equipment Reimbursement and Coverage Criteria are applicable.

Durable Medical Equipment (DME) for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Medical Supplies

A. The payment for purchase of Medical Supplies is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.

B. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Medical Supplies Reimbursement and Coverage Criteria are applicable.

Medical Supplies for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.